Health Information Technology Standards Committee
Final
Summary of the March 27, 2012, Meeting

KEY TOPICS

1. Call to Order

Mary Jo Deering, Office of the National Coordinator (ONC), welcomed participants to a virtual meeting of the HIT Standards Committee (HITSC). She reminded the participants that this was a Federal Advisory Committee meeting, with an opportunity for the public to make comments, and that a summary of the meeting would be available on the web site. She conducted roll call, and turned the meeting over to HITSC Committee Chair Jonathan Perlin.

2. Opening Remarks

Perlin thanked everyone for their efforts since the last meeting. The group, along with the ONC, is well into the work of reviewing the Notice of Proposed Rulemaking (NPRM) for all of the aspects of Meaningful Use Stage 2.

National Coordinator for HIT Farzad Mostashari announced that MacKenzie Robertson is transitioning into the role of Federal Advisory Committee Coordinator. He sincerely thanked Mary Jo Deering, who stepped into the position with Judy Sparrow's departure. He and the Committee gave a round of applause to welcome Robertson.

He acknowledged that the amount of work does not let up, but it is incredibly exciting and their goals are within sight. Much of what he had hoped for in terms of a concerted push for standards-based exchange and interoperability for Stage 2 is in the NPRM. If they can pull this off, making sure that standards reflect the best thinking in the country today as to what is mature, adoptable, and good enough to move forward, then they will have done the nation a great service. The heartening aspect of this is that there seems to be near-universal consensus as to the need to be aggressive on standards-based interoperability and exchange.

Mostashari also acknowledged Sharon Terry, who created a fitness video in response to the Healthy New Year challenge to create a video demonstrating how individuals are using HIT to live healthier.

3. Review of the Agenda

Perlin asked the Committee for any additions or amendments to the minutes of last month's meeting. Hearing none, he declared the minutes approved.

> **Action Item #1:** The Committee approved the minutes of the February 29, 2012 HITSC meeting by consensus.

Perlin reminded the group that in its January meeting, the Committee set out a work plan for the year. For this quarter they anticipated the NPRM and Stage 2 standards, and their collective work in providing feedback to the ONC and the HIT Policy Committee (HITPC). Also this quarter, Jim Walker has been launching a second approach to quality measure standards.

Simultaneously, there has been a convergence with the response to the NPRM and work that was planned for Nationwide Health Information Network (NwHIN) Exchange.

In the next quarter, the Committee will continue working on NwHIN portfolio activities, directing a set of exchange activities that will create the set of tools to allow the interoperable ecosystem that Mostashari described.

Query Health is coming to life, and the HITSC will provide needed work and support to build out the query capability. One of the areas that they have known they would be working toward is radiology standards. In the next quarter, the Committee needs to converge on a set of activities to make sure that aspirations for private and secure transport become a part of the interoperability that is necessary for better care and better health.

ONC's Doug Fridsma has been leading the group through the evolution of the Standards and Interoperability (S&I) Framework, and Perlin hopes the Committee shares a sense of pride and satisfaction in taking these threads and weaving them together into the interoperability that supports use cases that aspire to being very real world-like. That goal will require a continuing evolution of their work and standards support, and also the curation of those products necessary to keep that ecosystem healthy and effective.

The third quarter will bring the elaboration of clinical models and support for consumer information exchange; and the final quarter they will take up public health and data portability, and conformance testing.

4. Comments

HITSC Co-Chair John Halamka said that they are on track with their work plan, reiterating Perlin's review of the year's schedule. Each Workgroup is currently reviewing the NPRM to look for ambiguities in the language and gaps.

5. Updates From ONC

ONC's Doug Fridsma discussed a few different ONC projects that are ongoing concurrently with the NPRM work. First, they have identified a lab results interface to the S&I Framework, leveraging some of the implementation specifications from Healthcare Information Technology Standards Panel (HITSP), as well as the expertise of the California Healthcare Foundation. Fridsma said he hopes they can create a specification that will be suitable not only for lab results but also for lab ordering.

Also, with respect to quality measures and clinical decision support, Fridsma said these are two sides of the same coin. He hopes they can make it easier to implement correctly the quality measures, and turn those into clinical decision support.

Other ongoing activities at ONC include working with Representational State Transfer (RESTful) approaches and the Transport Layer Security (TLS) approach, letting people know about those as they become refined and ONC has more direction. They are working with ONC's Chief Privacy Officer Joy Pritz and the privacy and security group that she has organized to make sure there are certifications and trust infrastructure in place for directed exchange.

Fridsma expressed the desire to hear Committee discussion regarding Consolidated Clinical Document Architecture (CCDA) as an underpinning foundation for supporting transitions of care. It is important to understand is that CCDA cleans up implementation specifications, making it clearer to implement and creating a way of assembling the necessary pieces to share clinical information.

He used the example of a penicillin reaction. It could be that someone took penicillin and developed a milk rash. Or, they could have taken penicillin, had trouble breathing, and gone to the hospital. Those elements are collected into an allergy observation in an allergy template at section level. CCDA takes these individual observations or pieces of information and puts them into logical sections from a clinical perspective. Then, through the process of transitions of care and consolidated CDA work, those section level templates are assembled to support different transitions, and different kinds of documents. A transition of care document might include an allergy section, maybe some diagnoses, and some procedures. The CCDA standard has tried to collect individual data into logical sets of things and putting them into sections, and then deciding which sections would be relevant in a document to sensibly exchange information in a given situation.

The more specific and unambiguous they can be about what is required to support information exchange, the more likely they are to get to interoperability. Fridsma acknowledged that if there is some unique characteristic about the consult or the hospital, it can be hard to include unless they think very flexibly. This is a tension that this Committee will face in the work.

He discussed composing the 2014 edition of the CCDA, saying that the current CCDA did not refer back to transitions of care. A lot of it had to do with the timing, but it is important to think through whether they want to have sections and entries as a way to describe a standard. It may make it more flexible, but harder to get to interoperability.

It is important to strategically determine the right level to specify the standard and understand the tradeoffs between lower level elements. For example: eight sections are needed to describe continuity of care.

Next, Fridsma offered a separate update on the National Information Exchange Model (NIEM) Section 1561 Update. The Accountable Care Act specifically called out this Committee, charging it with identifying standards that would allow health insurance exchange. They did get some draft standards together and with some support from ONC, Mitre, and some contractors, they were able to meet the 120-day deadline set by the Act. Now CMS is implementing the federal insurance exchange, and it is important to notice that they are using those draft standards as a guideline, and not necessarily following them specifically.

There is a very aggressive timeline to develop health insurance exchanges and have them ready when the legislation becomes active.

Those participating in state efforts know that there are state exchanges, but for those states choosing not to develop their own insurance exchange, they can use the federal exchange. For

all those exchanges to work together, it is important to have consistency and appropriate standards between various components.

CMS has been asked to continue the work on Section 1561, to provide visibility for the challenges that they are having in its implementation, and to make sure they are on the right track in choosing standards that will not make it difficult to operate.

Fridsma proposed forming a working group based around NIEM to see how CMS is doing with implementation, and to offer transparency into process, guidance, and support for the work. If the Committee is amenable to this idea, he would like to get some volunteers for a team to help assure that these insurance exchanges have the ability to share information in ways that meet the requirements.

Discussion

Halamka noted that in the course of the work, Mitre said they had expected a summary document to be a lifetime summary, not an episode of care summary document. He asked if the consolidated CDA will be more longitudinal than episodal. Related to that, he said that when sending information to registries, they are finding that CCD is not perfect, because it is underspecified. Finally, as they start thinking about multiple patient reports, like batch submissions to registries, he asked whether the standards would allow health care organizations to submit more than one patient's data in a construct at a time.

Fridsma said that before transitions of care activities, the CCDA started to clarify section level activities. Then the transitions of care team began to organize document level templates that would support particular use cases. With regard to the quality use case, it is important when considering these standards, whether they reuse CCDA templates or come up with others, that they not overload a standard that has been used for one purpose, and use that same standard for another purpose. As Halamka pointed out, sometimes the necessary information is not contained in a single episode but it is available over a long period of time. They could look at other ways to assemble building blocks together, or go back to CDA standard from HL7 and look at Quality Reporting Document Architecture (QRDA), for example. That allows individual patient-level reporting, but also a row-and-column approach that would allow for bulk handling and summaries.

One Committee member suggested that they support efforts to harmonize standards for insurance exchange, because that is one of the first areas where there is patient-generated data in the exchange. It includes a good deal of information about demographics, health history, etc.

Fridsma noted that a challenge is that in some cases decisions will need to be made that will require implementation before standardization. That is not necessarily bad, but it is important that there be some transparency so that if there are issues about the path they have chosen, questions will be raised early so that they can mitigate and risk manage.

Arien Malec said that the discussion of document versus section is one that they had when they did the work on transitions of care. They felt it was important to standardize at the section level because there are a large number of kinds of transitions of care, some of which may be more or

less specific. There is a policy interest in having a subset of information that everyone can consume, even a poor set that everybody understands with the ability to add additional information over time. If CMS wants to use CCDA for the scaffolding for the minimum data set (MDS), it would be useful to have a core to the MDS that everybody could universally assume, even if they did not understand the MDS document. He acknowledged that some information would be lost in translation, which means it is important to render the entire document in HTML. However, the medications list, for example, should be understandable without the rest of it.

Malec said the transition of care work explicitly focused on three use cases: discharge, closed loop referral, and transition to long-term care. When everybody can support CCD, there is a tendency to treat it as the "hammer" and automatically look for the "nail" interface. They must recognize that even if they are around transitions of care, many people are going to try to use it for things that it was not specifically designed for. So they tried to design around a core of information that everybody can understand, with upward compatibility for more advanced use cases.

In response to a question by Wes Rishel, Fridsma said that they will be able to update the CCDA draft based on comments received during the comment period for the NPRM.

Fridsma responded to another question by Rishel related to with NIEM and the S&I Framework by explaining that NIEM has been used agency to agency across the government. ONC has responsibility for the health domain, and the Agency for Children and Families (ACF) has responsibility for the human services side. Those two agencies are working on intra-agency requirements. He pointed out that in large part the NIEM work, or the standards and implementation work that ONC is doing, is focused more on implementation than on the standards process. So in working with CMS, they must make sure they trade off the standards versus expediency, and provide insight into the choices being made.

Rishel said that CCDA is a plural phrase. It is intended to describe a set of standard documents, each of which is built using building blocks from templates contained in the lower levels of the diagram that Fridsma used to illustrate CCDA. It might include sections, and those sections might include individual data entry templates, and wherever possible, those will be reused in multiple sections, and the sections reused in multiple documents. But if the question is asked whether this document is conformant to the CCDA, it must be one of the enumerated CCDA document types. One cannot arbitrarily throw together some data entry templates and declare it a CCDA document. Rishel's understanding is that the hierarchy of levels of templates is what gives the context that allows for an understanding of what, for example, an individual medication means. So there are two virtues that they would like to support at the same time, though they are somewhat conflicting. One is the ability to send as much as possible, and the other is to receive the data that is needed in order to do a particular task. Many would have assumed that when it came to a discharge summary or transfer to a skilled nursing facility or the like, that there would be a document type within the CCDA family to describe that, and that document type would be what is required, and would be written into the regulation. In that way, there is the ability to be sure that the information the receiver required will be present in the document. Instead, a different approach that has a different set of virtues was adopted. What is sent and therefore required to be received must be some document that is a member of the CCDA family, and must

have certain identified data elements in it, although those data elements are not specified with respect to the context. They're specified just as entry-level templates, not as templates within a section. The advantage of that—and it is a big advantage—is that there are many kinds of encounters that are most appropriately described with different documents.

Rishel said that they must do more than simply test and certify interfaces. There must be a very active set of processes for allowing testing prior to certification and for working on issues in a social environment. He said he is pleased to see how much work is going on in that direction.

Dixie Baker referred to slide 3, which describes the header template. There are only three sections there, and none of those seem to be sections where on might put identify provenance and security metadata. She asked where those metadata would go in the CCDA section. Fridsma said he would go back to the team and make sure that information is included.

Perlin asked whether there was any objection to forming a working group to address NIEM issues. Hearing none, he told Fridsma that the Committee would be delighted to take on the project. He said that they should work in the interim to develop an approach that integrates with the rest of the Committee's activities.

Action Item #2: The Committee agreed to form a NIEM Workgroup.

6. Update From Implementation Workgroup

Implementation Workgroup Co-Chair Liz Johnson offered general comments on testing procedures. The Workgroup attempted to consolidate work done before the NPRM, which will be followed up in conjunction with the rest of the Workgroups going forward. They organized their findings into clinical work considerations and measurement considerations. It is critical that the test procedures recognize that these will be used in clinical environments.

Committee members were provided with a 31-page document that reviews the NPRM measure by measure and provides extensive comments. Johnson said the group is just beginning a work plan to talk about what is coming next from this group. There will be the completion of the comments on the testing procedures, and then the completion of comments on meaningful use certification criteria. The group feels that it is critical that clinical scenarios be utilized for testing. They are beginning to identify activities that would bring in public and community insight into the implementation challenges.

She walked the group through a slide deck that showed highlights of the Workgroup's report, and offered the group's help in developing clinical scenarios to be used as part of the testing procedure, which Perlin and Halamka both gladly accepted.

Discussion

Leslie Kelly Hall had questions about accommodating future thinking, and around clinical decision support testing. She asked whether any consideration had been given to accommodating the idea of both real-time and asynchronous decision support. Decision support could be used for immediate information, like labs, etc. It could also be used when there are

other consultations going on. Shared decision making would involve asynchronous decision support. Also, she asked about the logical place for patient inclusion. Have they started to think about how that might be worked into implementation testing today?

Johnson said that Hall's comments will further clarify their thinking on the testing procedure. Even the use of the word "asynchronous" further clarifies what they are trying to do. Patient inclusion is not something the group talked about, but they will discuss where that could be included, and whether it is something that can be included in this round.

7. Update From Clinical Operations Workgroup and Vocabulary Task Force

Clinical Operations Workgroup Chair Jamie Ferguson said the Workgroup is in the process of drafting their comments. He expressed appreciation for the clarity and improvement in drafting of this NPRM. The first of the areas where they plan to develop specific comments is the encounter-diagnosis data element, where International Classification of Diseases (ICD) is specified. He questioned whether the intent of that was for the billing use case or to capture clinical diagnosis. In general, where the diagnosis is mentioned in the NPRM it is intended to be used in clinical cases. So if the intent is clinical, Systematized Nomenclature of Medicine-Clinical Terms (SNOMED) should be used; if it is for billing and administration, then ICD would be better. If it is possible to add a second field, it might be useful to have both.

That issue led to a discussion in the Workgroup about the clinical friendliness of SNOMED for clinical documentation. They have heard that clinicians prefer it, but with regard to using SNOMED for the problem list, there is an issue with data entry. Post-coordination, they heard form different Workgroup members about different approaches. All seemed to work equally well, but that could be problematic.

The Workgroup discussed discharge prescribing in eligible hospitals. If the intent is for internal operations versus external interoperability, then HL7 is used, but if the intent is strictly for external interoperability, then National Council for Prescription Drug Programs (NCPDP) standards with version notation is appropriate. Ferguson asked if the standard was required for a meaningful use measure. If use of that standard is not required, then it's fine not even to mention HL7. But if it is mentioned in meaningful use measures, then HL7 really must be listed in the regulation.

With regard to allergy vocabulary, Ferguson brought up a couple of questions on the use of UNII. They previously recommended the unique ingredient identifiers in UNI: RXNorm for medications, and SNOMED for causative effect. In the meantime, UNII has been added to RXNorm, so the question becomes which identifier should be used for the same concept.

They had a discussion on transmission protocols, feeling was that rule should support Secure/Multipurpose Internet Mail Extensions (S/MIME), Simple Mail Transfer Protocol (SMTP), and Simple Object Access Protocol (SOAP). All of these should be required, and they should leave it up to the implementer to decide which one to use.

With regard to groups of patients, the workgroup found that there is not a standard specified for groups or for panels of patients to be transmitted. However, for example, in registry updates that kind of transmission might be required. HL7 version 2 or 3, or CDA could be used for this

purpose, but there isn't an implementation specification that could send a batch of patients to the registry in that sort of update. This could also be applicable to adverse event reporting with groups of patients.

Ferguson suggested that country of birth or origin as a required demographic data element could be more important than a race/ethnicity code in some cases. He said the Workgroup discussed other such items, but felt that they did not want to recommend particular standards.

On their next call they will discuss medical reconciliation and transitions of care, as well as the scope and use of an information button in terms of clinical decision support. They will take those up next in addition to drafting and refining the comments on the NPRM.

Discussion

John Halamka said that recognizing the family history is certainly important and there are multiple approaches, but it seems at the moment that the XML from the Surgeon General's Web site is most widely deployed.

Nancy Orvis pointed out that Ferguson mentioned RXNorm for unique medicine codes. She asked whether that would also be true for the drug classifications. Ferguson said yes, and Orvis asked if there would be a comparable smoothing for allergies. Ferguson said that RXNorm addresses drug and non-drug allergies, including inactive ingredients. Orvis suggested that they should create a modernization chart to illustrate what they used to use, and what they will now be using because RXNorm has matured. She offered to help with this project. She suggested this because some have been working on that standard for about 6 or 8 years, and anything they can do to help educate those who have been using RXNorm for about five years would be helpful. Ferguson said he thinks that should be easy.

Halamka explained that they identified that in the various efforts of vocabularies, they talked about using all these variables. Now the maturity of RXNorm allows a crosswalk among all of those to provide the richness of the different languages. Internally people can use whatever they want, and then take those internal codes and map them to some common vocabulary, so that over the wire there is one consistent set. The question was, what is the parsimonious set of CUIs, and it looks like RXNorm hit just about all of them.

Jim Walker said that they should make clear in the NPRM that SNOMED is the language to do clinical work in and then be able to translate to ICD for billing. Many organizations do not yet understand this concept, and it would simplify and clarify a lot of organizations' approaches if they recommend this. Regarding country of origin, Walker said he appreciates the clinical reality, but the construct is not clear. He urged them to really figure out what they are trying to get to, with regard to this issue and also family history. They should not be asking people to document family history that has no predictive value.

Walker also wondered whether certification of drug information provider organizations would be worth exploring. Many organizations have the experience that there are pervasive and relatively easy-to-fix problems with those information services, of which there are maybe only three. If those issues could be fixed, it would make it far easier for health care organizations to better manage a full set of critically important issues.

David McCallie said that sometimes in order to match SNOMED codes with the granularity of an ICD-10 code, you would need to use post-coordinated SNOMED. Does this include a standard approach to the post-coordination? Ferguson said that the Workgroup discussed the usability of systems where post-coordinated care is required, but they did not go as far as specifically mapping post-coordination concepts to ICD. In previous comments from the Vocabulary Task Force there was a set of recommendations about having all of the vocabulary sources available from a single federal office or agency through a set of consolidated services. That standardized crossmap of whatever will be required could include post-coordinated terms and mapping to ICD. It might be useful to review and reinforce those comments.

McCallie is also concerned about the interoperability implications of post-coordinated SNOMED expressions. If they limit it to specific use cases it probably will not be a problem, but SNOMED itself does not have an automatic way to do that.

Arien Malec said his particular interest is allergies or intolerances to drug classes. One of the issues with class terminology is that they are used for multiple purposes. He used as an example a topical dermatological agent versus a set of compounds with a common mechanism of action. A certification-enforced minimal set of high-value classes that are linked to significant allergies or intolerances would help the major database drug vendors get to some interoperability. Anyone who has done class-based interoperability knows that it is very difficult at present.

Halamka asked whether the Vocabulary Task Force could make a recommendation as to the nature of what these various proprietary vocabularies should be able to map to. Ferguson said there are subsets that are available, but he does not know of a particular subset that has been designated for this purpose that is now available, before the final rule. Malec said that, to the extent that there are well-known and well-documented allergies and interactions, there is a short list that could be targeted. If none exists, perhaps that should be a high priority research topic for the National Library of Medicine (NLM). Halamka said he would send out a black box list of those categories of substances that should never be combined.

Farzad Mostashari said that they also have to be thinking about the mechanism of dissemination and maintenance. Before they go out and develop the content, they need to look at who's going to use it and why, and how it will be maintained over time.

Jim Walker pointed out that if there was some minimal certification requirement that would have the effect of relieving these companies of legal liabilities, then that would make the information useable to consumers. He acknowledged that this does not answer Mostashari's question about who would be the custodian of the information.

Wes Rishel said he does not understand the assumption that the problem, the specific field in the EHR, determines the numerator or denominator for various quality computations. It would be ideal to state those computations in terms of the same problem code that is used in the EHR, but they all know that the actual business of creating problem entries for patients in the EHR is difficult. The computer is trying its best to track a very dynamic and social process among multiple physicians caring for a patient. The simple notion that the problem list is a complete list of problems as identified for issues of quality reporting is probably naïve. He wonders whether the apparent notion that there is a clear automatic mapping from the SNOMED description of a

problem, and the appropriate categorization of a problem for purposes of billing or workload tracking where there is not direct reimbursement is even feasible. He can understand that it is possible to compute a SNOMED representation for an ICD10 code; he cannot understand whether what generates appropriate billing can be generated out of what has been generated clinically.

Ferguson said there are cross-maps from the clinical problem coding to the billing coding for encounter-diagnosis that are widely used and published by NLM. There are also efforts underway to publish an international standards map. They saw a preview of that map during an earlier meeting, and it is available on the Internet.

Mostashari said that one cannot successfully make a problem list just for the purpose of meeting meaningful use. He has heard from hospital Chief Medical Officers who have said they are maintaining an active problem list just for the sake of meaningful use and it is not working very well. He has also heard from others who said that they are making use of the concept of an up-to-date clinical problem list and it has become an integral and irreplaceable part of the workflow. Assuming that does happen, that the problem list is maintained and is useful for clinical care, the question is whether they could reduce the work required to generate the information needed for the billing details.

Jim Walker suggested that they take a two-tiered approach. They should view the problem list as the model for the patient's reality well enough that a clinician can look at it and have a fairly clear idea of where to start. Then there are a certain set of problems that represent about 95% of clinical volume, and another set that are extremely specialized that represent a patient's unique situation. There ought to be a small set of very clearly recognizable problems that entail clear care plans and outlines for doctors, nurses, and case managers. Then there must be another set for a specialist to be able to say whatever they need to say about a patient's perhaps highly unusual situation. It might be helpful to look at that rather than as it just a single problem.

Rishel said he is concerned that there are a lot of hypotheses here, and some specific regulation deadlines that require certification and require meaningful use that are not flexible with regard to verifying these hypotheses. So they must pick a unit of progress, a path of least regret that is manageable in this timeframe, and that leaves open all of the possibilities that are being described here.

8. Update From Clinical Quality Workgroup

Clinical Quality Workgroup Chair Jim Walker said that his group reviewed the NPRM comments on clinical decision support, clinical information reconciliation, quality measures, and the problem list. The Workgroup has had one meeting, so their comments are preliminary at this point.

The Workgroup will divide into two teams to get the work done. One will focus on the essential components of what a usable and useful quality measure would be, and the other will look at the values fundamentally, identifying value sets and other components that will be usable and useful to people.

He presented a slide with preliminary NPRM feedback, which will be further ordered and prioritized by the next meeting.

9. Update From Consumer Engagement Power Team

Consumer Engagement Power Team Chair Leslie Kelly Hall said that a good number of people have volunteered to be on the Team, and she reviewed its charge.

The Power Team will prioritize recommendations that will enable patients to participate as partners in their care. The patient engagement objectives and meaningful use are being addressed in the Policy Committee, so this Team will instead be looking at the overall standards and how they might be further enhanced to promote patients as partners in their own care.

Mostashari said that as they move beyond the immediate needs of the NPRM on the clinical side, it will be important to begin working with stakeholders, particularly health plans and CMS on the administrative data side as well. Some of the country's biggest insurers have committed to enabling a blue button download of personal health information. Is there a standards question there in terms of what information will be included in that code set and how it will be implemented? Mostashari said he wanted to make sure that was included in future discussions.

10. Update From Privacy and Security Workgroup

Privacy and Security Workgroup Chair Dixie Baker said that their team completed the review of the NPRM. Overall they thought ONC did a great job. In her slide deck, Baker outlined a few recommendations. In the transport standard references, the citations themselves are not complete and accurate. The first two are Direct standard specifications, and the third one references SOAP. This may have to do with the modular specifications that are being developed by the S&I Framework. The Workgroup knows that the people working on the S&I Framework are aware of this issue.

The Workgroup's other concern is about confusion as to what is required, because of inconsistency between two certification criteria that reference these transport standards. Transitions of Care requires Direct transport, and SOAP is optional. Transmit to Third Party requires only the two Direct specifications, and does not mention the third one. The criteria need to be consistent for vendors to avoid confusion.

Another area of misunderstanding relates to the patient-accessible log. Interestingly, everybody thought they understood this, but had different understandings of what it meant. Baker explained, there is a requirement for a patient to be able to generate an audit log. Some thought this derived from a HITECH requirement that providers be able to transmit an electronic record upon request. The Workgroup thought the accessible log was a log of activities on a patient portal. However, others believe this points to the accounting of disclosures log, which should be accessible to patients. That needs to be clarified.

Also, there are certification criteria for secure messaging with patients, but the criteria for allowing the patient to view their record and download does not have any associated security requirements. The Workgroup recommends that the same certification criteria for secure messaging be used to generate another criterion to apply to viewing and downloading.

The NPRM does not cite transport layer security or HTTPS as a standard, but actually it is probably better that way. It specifies that authentication is required, and also that encryption and integrity protection are required. This doesn't lock them into a protocol, allowing more

flexibility for the future. The workgroup thought the same approach should be applied to download and viewing; they like the approach in general.

Discussion

Leslie Kelly Hall emphasized that patients must have the ability not only to view and download their record, but also to be able to transmit it themselves. Arien Malec agreed with Hall, and said that in the Implementation Workgroup they have been talking about the privacy and security implications of that. There is a level of privacy and security that needs to be in place. He wonders whether the Privacy and Security Workgroup could look at security practices for patient-facing technologies. Baker agreed that the safety implications are important to consider.

Rishel amplified Malec's comments. He said that a vendor might provide a patient portal within an EHR or any developer could provide that capability as a modular certified patient portal. The statistics from Meaningful Use Stage 1 indicate that there are about 800 such vendors, and so the number of vulnerabilities associated with adding a web site for the first time to a product and hosting it in a small practice is a pretty substantial risk. Given that there are alternatives such as working with a third party that is modularly certified, how do these final rules balance against the risk to provide information to patients?

Malec proposed that they make clear that when they are going from secure hosting within the practice to an outside situation, that there will be a distinction made in terms of security. Organizations used to managing security in a small boundary are now going to the Internet. They must be clear what they are taking on, and provide a path within a core EHR where they can work with a third party who knows how to deal with the web in order to get those requirements met.

Halamka pointed out that this is a Policy Committee Privacy and Security Tiger Team issue. Rishel concurred, but said that after the policy discussion, there is a good chance that it will get reflected back to the Standards Committee for answers to some specific questions, such as whether there are security certification requirements associated with the modules that provide Web access for consumers.

Jim Walker said that this is a matter of approach that is reflected in language. Sophistication in matters of computer security is not the difference between professionals and lay people. The difference is in obligation. The professional is obligated to follow safe practices for guarding information.

11. Discussion on Cross-Workgroup Coordination

Perlin expressed appreciation for all the Committee's work in response to the NPRM. He announced that Liz Johnson has been proposed as the Standards Committee representative to the Policy Committee.

> **Action Item #3:** Liz Johnson was chosen as the Standards Committee representative to the Policy Committee.

12. Briefing on Long-Term and Post-Acute Care Activities

John Derr spoke briefly, saying that he will bring a full presentation to the April meeting, after he has gone before the Policy Committee. He said that ONC is paying a lot of attention to long-term post-acute care, which he appreciates. Because of the second quarter objective, they have developed a roundtable of thought leaders that will meet May 3rd in Washington, DC.

He also announced that the 8th Long Term Post-Acute Care (LTPAC) HIT Summit will be held on June 18th. He will send the agenda to the Committee. They are also working on the comments that Mostashari asked for in the ONC proposal, as well as comments on the CMS proposed rule.

13. Public Comment
There were no comments.

SUMMARY OF ACTION ITEMS:

Action Item #1: The Committee approved the minutes of the February 29, 2012 HITSC meeting by consensus.

Action Item #2: The Committee agreed to form a NIEM Workgroup.

Action Item #3: Liz Johnson was chosen as the Standards Committee representative to the Policy Committee.